

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

accepted

PRINTED: 09/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Poc #1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 09/06/2012
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NAME OF PROVIDER OR SUPPLIER

FAIRPARK HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**307 N FIFTH ST BOX 5477
MARYVILLE, TN 37801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Complaint investigation #30404 and a revisit were completed at Fairpark Healthcare Center on September 6, 2012; following acceptance of an Allegation of Compliance to remove the Immediate Jeopardy at F-157 and F-250, Scope and Severity level "J," and F-223, F-226, F-490, and F-520, Scope and Severity level "K." The revisit revealed the corrective actions implemented August 30, 2012, removed the Immediate Jeopardy, but non-compliance continues at a "D" level Scope and Severity for F-157 and F-250; and at an "E" level for F-223, F-226, F-490, and F-520.	{F 000}	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
{F 157} SS=D	The facility is required to submit a plan of correction for the Immediate Jeopardy tags lowered in scope and severity. 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	{F 157}	F157 -It is the practice of this facility to immediately notify the attending physician of a significant change in a resident's physical, mental or psychosocial status requiring physician intervention. Immediately after Resident #1 communicated the allegation of rape on June 16 the facility notified the physician. The physician ordered the resident to be sent to the emergency room at the local acute care hospital, which was done. On August 16, 2012 the covering physician for the resident's attending physician, who was on vacation, was contacted and requested to write orders for the following lab tests: HIV, Hepatitis ABC screen, and RPR. Those tests (HIV, Hepatitis ABC screen, RPR) were obtained and the results returned negative for any	9/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Douglas D. Hammontree

TITLE

ADMINISTRATOR

(X6) DATE

9/13/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 157}	<p>Continued From page 1</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility investigation, review of a sexual assault forensic report, observation, and interview, the facility failed to immediately notify the Physician of a positive finding reported to the facility on August 2, 2012, from a sexual assault forensic report obtained after an alleged rape on June 16, 2012, for one Resident (#1) of twelve Residents reviewed. The facility's failure to notify the Physician immediately prevented the Physician from being able to speak with the Resident and/or the Resident's Family about treatment or potential treatment for sexually transmitted diseases (STDs) that may have been transmitted during the assault, for one Resident (#1) of twelve Resident's reviewed, placing Resident #1 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Resident).</p>	{F 157}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>sexual transmitted diseases. The resident's physician was on vacation from August 11 and returned on August 19. Resident #1 attending physician was notified by the Administrator on August 19, 2012 of the test results SAFE kit conducted at the hospital. Resident #1 was discharged from facility on August 16, 2012.</p> <p>The MDS Coordinator and the Unit Secretary, under the direction of the Director of Nursing, conducted an audit on all diagnostic tests ordered for current in-house residents, the audit was conducted from 8/21 to 8/24 diagnostic tests completed since June 15, 2012. The audit was performed to validate that the physician had been notified in a timely manner as per regulations and facility policy. The facility found that all lab tests had been reported timely to physicians. An additional audit was conducted by the Staff Development Co-ordinator on 8/23/2012 to ensure that families and physicians had been notified of all events occurring from 6/15/2012 to 8/22/12 and no issues noted.</p> <p>As of August 27, 2012 all licensed nurses employed by the facility, received in-service education on Guidelines for Physician Notification of Change in Condition, physician notification for lab results or Vital signs--including but not limited to diagnostic tests, resident events, and resident significant change in condition. The in services were presented by the District Director of Clinical Operations. The Facility does maintain a diagnostic test log which has been modified to include: additional physician notification information, physician ordered treatment changes, and family notification of changes. Monday through Friday morning clinical rounds are conducted by the Director of Nurses, Assistant Director of Nursing, or Staff Development Coordinator. The 24hr nursing report, new physician orders and diagnostic log will be reviewed to validate as completeness and to ensure that all diagnostic test results received by facility were been reported to the attending physician as per regulations and facility policy. Facility policies and procedures were reviewed by the Administrator, Director of Nursing and District</p>		

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{F 157}	<p>Continued From page 2</p> <p>The facility provided a Credible Allegation of Compliance on August 30, 2012. A revisit conducted on September 6, 2012, revealed the corrective actions implemented on August 30, 2012, removed the Immediate Jeopardy.</p> <p>Non-compliance for F-157 continues at a "D" level citation (potential for more than minimal harm).</p> <p>The findings included:</p> <p>Validation of the Credible Allegation of Compliance was accomplished through medical record review, facility policy review, in-service reviews, and interviews with facility staff, including administrative staff.</p> <p>Resident #1 was discharged to another facility on August 16, 2012.</p> <p>The facility provided evidence the on-call Physician was notified on August 15, 2012, and ordered testing for sexually transmitted diseases (STD's), to include HIV (Human Immunodeficiency Virus); Hepatitis A, B, and C; and RPR (Rapid Plasma Reagin). The tests were completed on August 17, 2012, and were negative.</p> <p>The facility provided evidence of reviews of diagnostic test completed since June 15, 2012, to ensure the Residents' Physician had been notified in a timely manner.</p> <p>The facility provided evidence of the revised policy, Notifications, to ensure the Residents'</p>	{F 157}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Director Clinical Operations, on 8/30/12. The facility has amended the policy/procedure to clarify notification of physicians for any offsite testing when the facility is made aware of the results. The policy on "Notification" was amended to include physician notification of any offsite test results that are provided to the facility. In addition to reviewing daily (Director of Nursing will review Saturday and Sunday results on Monday) at Clinical Rounds the Director of Nursing will review weekly the audit of diagnostic testing to validate that physicians are being timely contacted. The physician will be notified at that time if there are any changes in condition or lab values that should have been communicated. The results of this auditing will be brought to the Facility Performance Improvement Committee monthly x 3 months to address any issues involved in notification of change in condition. The Facility Performance Improvement Committee at its scheduled meeting will review the audits and make any recommendations for needed changes and then evaluate effectiveness.</p>	

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{F 157}	Continued From page 3 Physician is notified of all offsite diagnostic testing results. The facility provided evidence of in-services related to policies and procedures for Guidelines for Physician Notification of Change in Condition and diagnostic testing, including in-house and offsite diagnostic tests. Interviews with random facility licensed nursing staff, the Director of Nursing, and the Administrator, during the revisit, confirmed they had received in-services related to Guidelines for Physician Notification of Change in Condition and Physician Notifications. The facility remains out of compliance at a "D" level until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.	{F 157}	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
{F 223} SS=E	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility investigation, review of facility training	{F 223}	F223 -The facility does ensure each resident is free from verbal, sexual, physical, and mental abuse, corporate punishment and involuntary seclusion. On August 3, 2012 the facility was informed that the allegation of rape made in June by Resident # 1 was now being considered as possibly having occurred due to the results of the forensic testing. Resident #1 was discharged from facility on August 16, 2012. An audit was conducted VP of Clinical Ops on August 30, 2012 of all events occurring from January 1 2012 to August 30 2012, no other allegations of sexual abuse were reported. An additional audit was conducted by the Staff Development Co-coordinator on 8/23/2012 to ensure that families and physicians had been notified of all events occurring from 6/15/2012 to 8/22/12 and no issues noted	9/13/12	

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{F 223}	<p>Continued From page 4</p> <p>program, review of facility policy, review of payroll hours, review of an interview schedule, review of a sexual assault forensic report, observation, and interview, the facility failed to protect one Resident (#1) with Alzheimer's Disease (a common type of Dementia, in which a loss of mental ability is severe enough to interfere with normal activities of daily living) from sexual abuse of twelve Residents reviewed. The facility's failure to prevent sexual abuse and failure to immediately implement interventions to protect residents from the potential of the abuse reoccurring placed all Residents with Dementia in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Resident).</p> <p>The facility provided a Credible Allegation of Compliance on August 30, 2012. A revisit conducted on September 6, 2012, revealed the corrective actions implemented on August 30, 2012, removed the Immediate Jeopardy.</p> <p>Non-compliance for F-223 continues at an "E" level citation (potential for more than minimal harm).</p> <p>The findings included:</p> <p>Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, in-service reviews, and interviews with Residents, facility staff, including administrative staff and security guard staff.</p>	{F 223}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Interviewable residents and families of non interviewable residents were questioned by the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Business Office Manager, Activity Director, Director of Social Services, Admissions Coordinator, Director of Medical Records, Infection Preventionist, Certified Dietary Manager, Case Manager, MDS Coordinator, and Rehab Tech (Certified Nursing Asst), between August 23 and August 28, to determine the following: if there were any further allegations related to staff treatment, did residents feel they were treated with respect, had residents witnessed any unusual visitors, strangers or had concerns about any staff members. The interviews did not produce any other allegations of sexual abuse nor provide any potential leads for suspects. It was the understanding of the Executive Director from the police department that the facility was to refrain from re-interviewing staff members in August. The police officer indicated that this was now his investigation and he wanted to be the person to question male staff employees and procure DNA samples. The police advised the facility that in doing so it may impede or interfere with law enforcement's ability to correctly conduct its criminal investigation and to identify and prosecute the perpetrator. The facility agreed to fully comply with the request of the local police and did so based on policy and procedure of the facility "Responding to and Investigating an Abuse Allegation". The interdisciplinary team consisting of MDS coordinator, RN Case manager, Director of Social Services, Activity Director, Registered Dietician and Certified Dietary Manager identified the residents on 8/29/2012 that may be at higher risk for abuse due to dementia diagnosis, infrequent or no visitors, behavioral issues, or those who are bedfast and dependent on care. The interdisciplinary team met on 8/29 through 8/30/12 to identify care plan goals and interventions to assist in the prevention of abuse. This increased focus on</p>	

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{F 223}	<p>Continued From page 5</p> <p>Resident #1 was discharged to another facility on August 16, 2012.</p> <p>The facility provided evidence Residents and families of non-interviewable Residents were interviewed for allegations of abuse; no abuse was alleged.</p> <p>The facility provided evidence the Interdisciplinary Team assessed, identified, and updated care plans of Residents who may be at a higher risk for abuse.</p> <p>The Resident Council met and security concerns were discussed.</p> <p>The facility provided evidence of updated background checks on all male staff except two, with no negative findings. The delay in the two background checks is due to previous out-of-state residences, and the Administrator confirmed the results are expected at any time.</p> <p>The facility provided evidence of around-the-clock interim security personnel effective August 30, 2012, through September 4, 2012. A contract for around-the-clock security personnel was obtained effective September 5, 2012; and the contract does not identify a termination date.</p> <p>The facility provided evidence of a revised policy, Abuse Prohibition.</p> <p>The facility provided evidence a Security Workgroup had been developed to ensure enhanced security measures were identified and implemented.</p>	{F 223}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>residents who may be at higher risk for abuse has been communicated to the Certified Nursing Assistant staff via their assignment sheet and by placing a copy of the resident care plan for higher risk of potential abuse "Social Isolation" in the C.N.A. flow sheet book. Licensed nurses have a copy of the resident care plan for higher risk of potential abuse, "Social Isolation, with the resident's Medication Administration Record. The Activity Director and Director of Social Services conducted a Resident Council meeting on 8/29/2012 to discuss any security concerns of the residents. During this meeting the residents indicated to the Administrator that they felt safe here.</p> <p>The corporate Human Resource department is obtaining updated background checks on all male employees on 8/30/2012 to identify any current issues. Updated background checks on all male employees hired before June 15, 2012 has been completed and all areas are negative.</p> <p>A security assessment was completed on 8/30/2012 by a police officer of the City of Maryville. The officer conducted a tour of the facility as well as the grounds of the facility. A verbal recommendation from the officer was for the facility to hire a security guard pending the outcome of the police investigation around the clock to enhance the facility's security measures surrounding visitors sign in/out procedures, and provide additional security support until a perpetrator is identified and taken into custody. The center has obtained security personnel through the Blount County Sheriff Department starting 8/30/12 until a replacement security contract is obtained. The facility will re convene the Performance Improvement security workgroup at that time to evaluate the recommendations and present them to the Performance Improvement Committee for review and action. The members of the Security Workgroup are: Maintenance Director, Administrator, Director of Nursing, Activity Director, Staff Development Coordinator, Housekeeping Supervisor and Patient</p>		

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{F 223}	<p>Continued From page 6</p> <p>Observation of the 100 hall Medication Administration Record confirmed a copy of Residents' care plans who are at high risk for potential abuse.</p> <p>Observation of the Certified Nursing Assistant Flowsheet book confirmed a copy of Residents' care plans who are at high risk for potential abuse.</p> <p>Observation of the front lobby confirmed a security guard was constantly present except for breaks, which are covered by facility staff. Visitors were observed to sign-in on the visitor's log upon entering the facility, and sign-out upon exit. When the front door is locked down, beginning at 6:00 p.m., the security guard makes random, periodic rounds inside from the front lobby to the courtyard door, outside rounds are made around the building, to include the inside and outside of the courtyard. The security guard confirmed routine, timed, rounds are avoided, to ensure a pattern is not established and discovered by a potential perpetrator.</p> <p>Observation of the service hall entrance confirmed the doors were locked and required staff to open the doors for vendors from the inside. Review of the vendor sign-in sheets revealed the sheets were being completed according to policy.</p> <p>Observation of the courtyard door confirmed codes are required to enter and exit. Continued observation confirmed staff covered the code pad to prevent unauthorized individuals from obtaining the code.</p>	{F 223}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Relations Coordinator</p> <p>Facility policies and procedures were reviewed by the Administrator, Director of Nursing and District Director Clinical Operations on 8/30/12. Two minor changes were made to the written policy and procedures. On 8/21/12 an Addendum to Facility's Abuse Prohibition Policy and Procedures was made to clarify the term "visitors" to include both family/friends as well as other professional consultants or visitors such as but not limited to: Paramedics, EMT's, Radiological Techs, laboratory techs, Physicians, Nurse Practitioners, clergy, attorneys, and legal representatives. On 8/30/2012 the policy on "Notification" was amended to add that physicians will be notified for lab test results or other test results returned from another laboratory or healthcare site that the resident was seen. The Administrator conducted in-services for facility staff on definitions of abuse, recognizing signs of possible abuse, protection of resident, Elder Abuse Act. These in-services were conducted beginning on 7/30/12, 7/31/12, 8/9/12, 8/22/12 and 8/24/12 for facility staff. Staff who are on leave, PRN, etc. will not be allowed to return to work until receiving the same in-service. The comprehensive practice for alleged abuse events will include documentation of the investigation on the "Alleged Abuse Investigation Worksheet". This worksheet identifies details of the incident, lists all possible witnesses, documents witness interviews, and identifies actions taken to prevent resident from a re-occurrence. Upon notification of an alleged abuse, the licensed nurse immediately ensures the safety of the resident and contacts the Administrator and Director of Nurses who will return to the center to conduct the investigation and utilize this worksheet. In the event that the Administrator or Director of Nursing are not available to conduct the investigation immediately, the back up investigators will include the Assistant Director of Nurses, the RN Case Manager, MDS coordinator and/or the Director of Social Services.</p>		

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{F 223}	<p>Continued From page 7</p> <p>Observation of the camera monitor confirmed three cameras were in operation and recording activity from the (1) front entrance, (2) service hall entrance, and the (3) employee locker room. The recording device and monitor is positioned in the front business office. The facility provided evidence recordings are reviewed daily, to ensure compliance with the visitor and vendor sign-in/out requirements (at the front and service hall doors).</p> <p>Observation of random Residents' rooms confirmed wooden dowels were present in the window thresholds to deter outside entry.</p> <p>The facility provided evidence of in-services related to policies and procedures for updated security measures; Abuse, including the definitions of abuse, recognizing the signs of possible abuse, protection of Residents; the Elder Abuse Act; and related documentation and worksheets.</p> <p>Interviews with random Residents and families revealed no knowledge of and/or allegations of Abuse.</p> <p>Interviews with random facility licensed and certified nursing staff, dietary and housekeeping staff, the Director of Nursing, and the Administrator, during the revisit, confirmed they had received in-services related to policies and procedures for updated security measures; Abuse, including the definitions of abuse, recognizing the signs of possible abuse, protection of Residents; the Elder Abuse Act; and related documentation and worksheets.</p> <p>The facility remains out of compliance at an "E"</p>	{F 223}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The District Director Clinical Operations conducted an in service on 8/23/12 to the above listed potential investigators on proper completion of this worksheet. On August 6 the facility convened a Performance Improvement Security Workgroup meeting. The members of the Security Workgroup are: Maintenance Director (Plant Ops Manager), Administrator, Director of Nursing, Activity Director, Staff Development Coordinator, Housekeeping Supervisor and Customer Service (Patient Relations) Coordinator. At this meeting enhanced security measures that could be put in place were identified.</p> <p>The lock codes were changed on 8/27/2012 for the main entrance, the vendor/service entrance and the court yard entrance. Exit codes were also changed and are different than entrance codes. Door codes will be changed every 30 days or more frequently if the code is compromised. The court yard gate will remain locked at all times unless under direct observation i.e., opened to bring in or remove materials such as lawn care equipment, yard debris, etc. The maintenance director or maintenance assistant will be responsible to unlock/lock and monitor gate during this type of activity. The key is secured in the maintenance office. Only Maintenance and Administrator have access to the key. The service door, which is for staff and vendor access only, is locked 24 hours a day/7 days a week. Staff may use access code to exit and enter. Vendors/delivery personnel must ring bell and have staff open the door. The staff who opens the door is responsible for having the vendor sign-in and sign out. The vendor sign in sheet is located at the delivery entrance. The Administrator, Maintenance Director, Director of Nursing, Business Office Manager, Asst. Director of Nursing or assigned week-end duty managers will monitor the vendor logs daily to ensure that vendors are signing in and out. Windows and screens were checked from the exterior on Aug 16, 2012 and found to be secure by the maintenance</p>		

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		F223	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Coordinator will track and trend events such as injury of unknown origin, information from resident/family interviews and allegation of abuse investigations, if any, to monitor and evaluate facility's abuse prevention program. The Director of Nursing will continue to present to the Facility Performance Improvement Committee at its monthly meeting any/all investigations of allegations of abuse that includes a review of compliance with the facility's P&P on Abuse Prevention & Investigation for review, discussion and recommendations, if indicated.</p>		

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(F 223)	Continued From page 8 level until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.	(F 223)	This Plan of Correction is the center's credible allegation of compliance.		
(F 226) SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility investigation, review of facility training program, review of facility policy, review of payroll hours, review of an interview schedule, review of a sexual assault forensic report, observation, interview, and review of video surveillance, the facility failed to thoroughly investigate and implement interventions to protect one Resident (#1) with Alzheimer's Disease (a common type of Dementia, in which a loss of mental ability is severe enough to interfere with normal activities of daily living) from sexual abuse of twelve Residents reviewed. The facility's failure to follow facility policy to thoroughly investigate and implement interventions immediately to protect the Resident placed Resident #1 and all Residents with Dementia in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Resident).	(F 226)	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>F226 - The facility does ensure each resident is free from verbal, sexual, physical, and mental abuse, corporate punishment and involuntary seclusion. On August 3, 2012 the facility was informed that the allegation of rape made in June by Resident # 1 was now being considered as possibly having occurred due to the results of the forensic testing. Resident #1 was discharged from facility on August 16, 2012. An audit was conducted VP of Clinical Ops on August 30, 2012 of all events occurring from January 1 2012 to August 30 2012, no other allegations of sexual abuse were reported. An additional audit was conducted by the Staff Development Co-coordinator on 8/23/2012 to ensure that families and physicians had been notified of all events occurring from 6/15/2012 to 8/22/12 and no issues noted.</p> <p>Interviewable residents and families of non interviewable residents were questioned by the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Business Office Manager, Activity Director, Director of Social Services, Admissions Coordinator, Director of Medical Records, Infection Preventionist, Certified Dietary Manager, Case Manager, MDS Coordinator, and Rehab Tech (Certified Nursing Asst), between August 23 and August 28, to determine the following: if there were any further allegations related to staff treatment, did residents feel they were treated with respect, had residents witnessed any unusual visitors, strangers or had concerns about any staff members. The interviews did not produce any other allegations of sexual abuse nor provide any potential leads for suspects. It was the understanding of the Executive Director from the police department that the facility was to refrain from re- interviewing staff members in August. The police officer indicated that this was now his investigation and he wanted to be the person to question male staff employees and procure DNA samples. The police</p>		9/13/12

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{F 226}	<p>Continued From page 9</p> <p>The facility provided a Credible Allegation of Compliance on August 30, 2012. A revisit conducted on September 6, 2012, revealed the corrective actions implemented on August 30, 2012, removed the Immediate Jeopardy.</p> <p>Non-compliance for F-226 continues at an "E" level citation (potential for more than minimal harm).</p> <p>The findings included:</p> <p>Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, in-service reviews, and interviews with Residents, facility staff, including administrative staff and security guard staff.</p> <p>Resident #1 was discharged to another facility on August 16, 2012.</p> <p>The facility provided evidence Residents and families of non-interviewable Residents were interviewed for allegations of abuse; no abuse was alleged.</p> <p>The facility provided evidence the Interdisciplinary Team assessed, identified, and updated care plans of Residents who may be at a higher risk for abuse.</p> <p>The facility provided evidence of updated background checks on all male staff except two, with no negative findings. The delay in the two background checks is due to previous</p>	{F 226}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>advised the facility that in doing so it may impede or interfere with law enforcement's ability to correctly conduct its criminal investigation and to identify and prosecute the perpetrator. The facility agreed to fully comply with the request of the local police and did so based on policy and procedure of the facility "Responding to and Investigating an Abuse Allegation" The interdisciplinary team consisting of MDS coordinator, RN Case manager, Director of Social Services, Activity Director, Registered Dietician and Certified Dietary Manager identified the residents on 8/29/2012 that may be at higher risk for abuse due to dementia diagnosis, infrequent or no visitors, behavioral issues, or those who are bedfast and dependent on care. The interdisciplinary team met on 8/29 through 8/30/12 to identify care plan goals and interventions to assist in the prevention of abuse. This increased focus on residents who may be at higher risk for abuse has been communicated to the Certified Nursing Assistant staff via their assignment sheet and by placing a copy of the resident care plan for higher risk of potential abuse "Social Isolation" in the C.N.A flow sheet book. Licensed nurses have a copy of the resident care plan for higher risk of potential abuse, "Social Isolation, with the resident's Medication Administration Record. The Activity Director and Director of Social Services conducted a Resident Council meeting on 8/29/2012 to discuss any security concerns of the residents. During this meeting the residents indicated to the Administrator that they felt safe here. The corporate Human Resource department is obtaining updated background checks on all male employees on 8/30/2012 to identify any current issues. Updated background checks on all male employees hired before 6/15/2012 has been completed and all areas are negative. A security assessment was completed on 8/30/2012 by a police officer of the City of Maryville. The officer conducted a tour of the facility as well as the grounds of</p>		

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{F 226}	<p>Continued From page 10</p> <p>out-of-state residences, and the Administrator confirmed the results are expected at any time.</p> <p>The facility provided evidence of around-the-clock interim security personnel effective August 30, 2012, through September 4, 2012. A contract for around-the-clock security personnel was obtained effective September 5, 2012; and the contract does not identify a termination date.</p> <p>The facility provided evidence of a revised policy, Abuse Prohibition.</p> <p>The facility provided evidence a Security Workgroup had been developed to ensure enhanced security measures were identified and implemented.</p> <p>Observation of the 100 hall Medication Administration Record confirmed a copy of Residents' care plans who are at high risk for potential abuse.</p> <p>Observation of the Certified Nursing Assistant Flowsheet book confirmed a copy of Residents' care plans who are at high risk for potential abuse.</p> <p>Observation of the front lobby confirmed a security guard was constantly present except for breaks, which are covered by facility staff. Visitors were observed to sign-in on the visitor's log upon entering the facility; and sign-out upon exit. When the front door is locked down, beginning at 6:00 p.m., the security guard makes random, periodic rounds inside from the front lobby to the courtyard door; outside rounds are made around the building, to include the inside</p>	{F 226}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>the facility. A verbal recommendation from the officer was for the facility to hire a security guard pending the outcome of the police investigation around the clock to enhance the facility's security measures surrounding visitors sign in/out procedures, and provide additional security support until a perpetrator is identified and taken into custody. The center has obtained security personnel through the Blount County Sheriff Department starting 8/30/12 until a replacement security contract is obtained. The facility will reconvene the Performance Improvement security workgroup at that time to evaluate the recommendations and present them to the Performance Improvement Committee for review and action. The members of the Security Workgroup are: Maintenance Director, Administrator, Director of Nursing, Activity Director, Staff Development Coordinator, Housekeeping Supervisor and Patient Relations Coordinator</p> <p>Facility policies and procedures were reviewed by the Administrator, Director of Nursing and District Director Clinical Operations on 8/30/12. Two minor changes were made to the written policy and procedures. On 8/21/12 an Addendum to Facility's Abuse Prohibition Policy and Procedures was made to clarify the term "visitors" to include both family/friends as well as other professional consultants or visitors such as but not limited to: Paramedics, EMT's, Radiological Techs, laboratory techs, Physicians, Nurse Practitioners, clergy, attorneys, and legal representatives. On 8/30/2012 the policy on "Notification" was amended to add that physicians will be notified for lab test results or other test results returned from another laboratory or healthcare site that the resident was seen. The Administrator conducted in-services for facility staff on definitions of abuse, recognizing signs of possible abuse, protection of resident, Elder Abuse Act. These in-services were conducted beginning on 7/30/12, 7/31/12, 8/9/12, 8/22/12 and 8/24/12 for facility staff. Staff who are on leave, PRN, etc. will not be allowed to</p>		

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NAME OF PROVIDER OR SUPPLIER

FAIRPARK HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

307 N FIFTH ST BOX 5477

MARYVILLE, TN 37801

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{F 226}	<p>Continued From page 11</p> <p>and outside of the courtyard. The security guard confirmed routine, timed, rounds are avoided, to ensure a pattern is not established and discovered by a potential perpetrator.</p> <p>Observation of the service hall entrance confirmed the doors were locked and required staff to open the doors for vendors from the inside. Review of the vendor sign-in sheets revealed the sheets were being completed according to policy.</p> <p>Observation of the courtyard door confirmed codes are required to enter and exit. Continued observation confirmed staff covered the code pad to prevent unauthorized individuals from obtaining the code.</p> <p>Observation of the camera monitor confirmed three cameras were in operation and recording activity from the (1) front entrance, (2) service hall entrance, and the (3) employee locker room. The recording device and monitor is positioned in the front business office. The facility provided evidence recordings are reviewed daily, to ensure compliance with the visitor and vendor sign-in/out requirements (at the front and service hall doors).</p> <p>Observation of random Residents' rooms confirmed wooden dowels were present in the window thresholds to deter outside entry.</p> <p>The facility provided evidence of in-services related to policies and procedures for updated security measures; Abuse, including the definitions of abuse, recognizing the signs of possible abuse, protection of Residents; the Elder Abuse Act; Conducting an Investigation, including</p>	{F 226}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>return to work until receiving the same in-service. The comprehensive practice for alleged abuse events will include documentation of the investigation on the "Alleged Abuse Investigation Worksheet". This worksheet identifies details of the incident, lists all possible witnesses, documents witness interviews, and identifies actions taken to prevent resident from a re-occurrence. Upon notification of an alleged abuse, the licensed nurse immediately ensures the safety of the resident and contacts the Administrator and Director of Nurses who will return to the center to conduct the investigation and utilize this worksheet. In the event that the Administrator or Director of Nursing are not available to conduct the investigation immediately, the back up investigators will include the Assistant Director of Nurses, the RN Case Manager, MDS coordinator and/or the Director of Social Services. The District Director Clinical Operations conducted an in service on 8/23/12 to the above listed potential investigators on proper completion of this worksheet. On August 6 the facility convened a Performance Improvement Security Workgroup meeting. The members of the Security Workgroup are: Maintenance Director (Plant Ops Manager), Administrator, Director of Nursing, Activity Director, Staff Development Coordinator, Housekeeping Supervisor and Customer Service (Patient Relations) Coordinator. At this meeting enhanced security measures that could be put in place were identified.</p> <p>The lock codes were changed on 8/27/2012 for the main entrance, the vendor/service entrance and the courtyard entrance. Exit codes were also changed and are different than entrance codes. Door codes will be changed every 30 days or more frequently if the code is compromised. The courtyard gate will remain locked at all times unless under direct observation i.e., opened to bring in or remove materials such as lawn care equipment, yard debris, etc. The maintenance director or maintenance assistant will be responsible to</p>	

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		F22.6	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>unlock/lock and monitor gate during this type of activity. The key is secured in the maintenance office. Only Maintenance and Administrator have access to the key. The service door, which is for staff and vendor access only, is locked 24 hours a day/7 days a week. Staff may use access code to exit and enter. Vendors/delivery personnel must ring bell and have staff open the door. The staff who opens the door is responsible for having the vendor sign-in and sign out. The vendor sign in sheet is located at the delivery entrance. The Administrator, Maintenance Director, Director of Nursing, Business Office Manager, Asst. Director of Nursing or assigned week-end duty managers will monitor the vendor logs daily to ensure that vendors are signing in and out. Windows and screens were checked from the exterior on Aug 16, 2012 and found to be secure by the maintenance director. To make resident room windows so that they cannot be opened from the outside by an "intruder," wood dowels were placed in the inside slides track to prevent the windows opening greater than 6 inches on August 14, 2012. The facility has purchased windows locks for the resident room windows and after approval from the State of Tennessee, Dept. of Health, Health Care Facilities Engineering were installed on 9/13/2012. All non-resident room windows are currently secured by an inside lock. The maintenance director, maintenance assistant, assigned week-end duty manager are checking the resident room windows daily to validate the current safety device is in place. Currently there are 3 camera's attached to a motion detector that records when there is movement detected. The cameras visualize the front entrance (camera installation 8/10/2012), the vendor entrance (camera installation began 8/30/2012 and completed 8/31/2012), and the employee locker room (camera installed in 2010). This recording will provide the facility with evidence to review if there are any events such as employee theft, or other events that occurred, its intent</p>		

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NAME OF PROVIDER OR SUPPLIER FAIRPARK HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 307 N FIFTH ST BOX 5477 MARYVILLE, TN 37801		
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		F226	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>is not to use as real time monitoring but provide a retrospective review. This is another mechanism for monitoring the compliance of the visitor and vendor sign in/out procedure. Results of daily review of the recordings will be reported in the weekday morning meeting. At the present time it is reviewed daily by the maintenance director (Plant Ops Manager), or the Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, 3 Business Office Assistants, Activity Director, Activity Assistant, Director of Social Services, Director of Admissions, Director of Medical Records and Data Entry Clerk. It is possible to watch the camera real time if circumstances warrant. The front entrance is locked down beginning at 6 pm. Visitors must ring the bell and security personnel or staff respond to allow visitors to enter and exit the facility. A "visitor's log" placed at the receptionist area is monitored by video cameras, facility staff and/or the security guard to ensure that visitors sign in and out. The Administrator conducted in-services for staff on the facility's updated security measures on August 18, 19, 21, 23, 24, and 28, 2012. Employees on leave of absence, vacation, etc, upon return will receive the same in-service on prevention measures by their department head or designee, prior to reporting to their job area. On August 23, 2012 the District Director of Clinical Ops conducted additional in-service training with Administrator, Director of Nursing, Case Manager, MDS Coordinator, Housekeeping/Laundry Supervisor, Activity Director, Social Worker and Asst. Director of Nursing on "Conducting an Investigation on an Allegation of Abuse" which included, but was not limited to, immediacy of investigation, notifications, interviewing alleged victim, alleged perpetrator, interviewing witnesses including staff, residents, family members, etc.</p> <p>The maintenance director, Administrator, Business of Manager or assigned weekend duty managers will be responsible to view the video taping of the front lobby,</p>		

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		F226	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>the employee locker room and the vendor entrance and report any concerns to the facility administrator daily. Any staff member not in compliance with enhanced security measures will be disciplined as appropriate. New hires will receive facility orientation to the centers enhanced security measures.</p> <p>The Facility's Performance Improvement Committee (Administrator, Director of Nursing, Medical Director, Asst. Director of Nursing, Staff Development Coordinator, Business Office Manager, RN Case Manager, MDS Coordinator, Activity Director, Director of Social Services, CDM, Plant Ops Manager) met on August 21, 2012 to address issues of security. Updates to the security measures will be provided, effectiveness of measures will be reviewed and further recommendations made as needed. The Administrator/Director of Nursing/Staff Development Coordinator will track and trend events such as injury of unknown origin, information from resident/family interviews and allegation of abuse investigations, if any, to monitor and evaluate facility's abuse prevention program. The Director of Nursing will continue to present to the Facility Performance Improvement Committee at its monthly meeting any/all investigations of allegations of abuse that includes a review of compliance with the facility's P&P on Abuse Prevention & Investigation for review, discussion and recommendations, if indicated.</p>		

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{F 226}	Continued From page 12 immediacy of the investigation, notifications, and interviewing; and related documentation and worksheets. Interviews with random Residents and families revealed no knowledge of and/or allegations of Abuse. Interviews with random facility licensed and certified nursing staff, dietary and housekeeping staff, the Director of Nursing, and the Administrator, during the revisit, confirmed they had received in-services related to policies and procedures for updated security measures; Abuse, including the definitions of abuse, recognizing the signs of possible abuse, protection of Residents; the Elder Abuse Act; Conducting an Investigation, including immediacy of the investigation, notifications, and interviewing; and related documentation and worksheets. The facility remains out of compliance at an "E" level until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.	{F 226}	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		
{F 250} SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	{F 250}	F250 - Resident #1 was discharged from the facility on August 16, 2012. The facility Director of Social Services initially met with Resident #1 on June 18 at approximately 11am. The facility Social Services Director continued to visit resident as well as talk with direct care staff who cared for resident at least 2 times a week for 2 weeks (this is not documented but based on interview with the Director of Social Services) to Resident #1 to monitor for any changes of mood and behaviors in conjunction with the daily monitoring of the nursing staff. Resident #1 was not assessed to have		9/13/12

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{F 250}	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, review of the facility investigation, review of facility policy, review of a sexual assault forensic report (Rape Kit), review of a facility training program, review of facility policy, and interview, the facility failed to provide medically-related social services for one Resident (#1) with an allegation of sexual assault, of twelve Residents reviewed. The facility's failure to follow facility policy to provide medically-related social services placed Resident #1 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Resident).</p> <p>The facility provided a Credible Allegation of Compliance on August 30, 2012. A revisit conducted on September 6, 2012, revealed the corrective actions implemented on August 30, 2012, removed the Immediate Jeopardy.</p> <p>Non-compliance for F-250 continues at a "D" level citation (potential for more than minimal harm).</p> <p>The findings included:</p> <p>Validation of the Credible Allegation of Compliance was accomplished through medical record review, facility policy review, in-service reviews, and an interview with the Director of Social Services.</p> <p>Resident #1 was discharged to another facility on August 16, 2012.</p>	{F 250}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>any changes or decline in her mental or psychosocial well-being up to and including her day of discharge from the facility on August 16, 2012.</p> <p>Resident #1 was visited by the by the consulting Geropsych Licensed Clinical Social Worker (LCSW) on June 18, 2012 and the resident declined to participate in an interview discussing the alleged incident. The result of (Licensed Clinical Social Worker) LCSW's assessment was that the Resident #1 had no change in behaviors or mood at this point. After discussion with the Administrator and Director of Social Services, it was decided that the LCSW (Licensed Clinical Social Worker) would not further address the alleged sexual abuse with Resident #1 unless she wished to do so, or if Resident #1 had been assessed to have changes in mood and behavior.</p> <p>An audit was conducted by VP Clinical Ops on August 30, 2012 of all events occurring from January 1 2012 to August 30 2012, no other events of alleged sexual abuse had occurred. Interviewable residents and families of non interviewable residents were questioned by the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Business Office Manager, Activity Director, Social Services Worker, Admissions Coordinator, Medical Records, Infection Preventionist, Certified Dietary Manager, Case Manager, MDS Coordinator, and Rehab Tech (Certified Nursing Asst), between August 23 and August 28, to determine if there were any further allegations related to staff treatment, did residents feel they were treated with respect, had residents witnessed any unusual visitors, strangers or had concerns about any staff members? The interviews did not produce any other allegations of sexual abuse nor give potential leads for suspects. The facility did not re-interview staff members in August at the request of the local police department.</p> <p>The interdisciplinary team consisting of MDS coordinator, RN Case Manager, Social Worker, Activity</p>		

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{F 250}	Continued From page 14 The facility provided evidence Residents and families of non-interviewable Residents were interviewed for allegations of abuse; no abuse was alleged. The facility provided evidence the Interdisciplinary Team, (including the Director of Social Services), assessed, identified, and updated care plans of Residents who may be at a higher risk for abuse. The facility provided evidence of in-services related to policies and procedures, Responding to and Investigating an Abuse Allegation, and related social work and/or psychological services in response to allegations of abuse. Interview with the Director of Social Services confirmed the Director of Social Services had received in-services related to policies and procedures, Responding to and Investigating an Abuse Allegation, and related social work and/or psychological services in response to allegations of abuse. The Director of Social Services revealed, "I have learned a lot through this...I will ensure all Residents with an allegation of abuse receive the required medically-related social services." The facility remains out of compliance at a "D" level until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.	{F 250}	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Director, Registered Dietician and Certified Dietary Manager identified the residents on 8/29/2012 who are at higher risk for abuse due to dementia diagnosis, infrequent or no visitors, behavioral issues, or those who are bedfast and dependent on care. The interdisciplinary team met on 8/29 through 8/30/12 to identify care plan goals and interventions to assist in the prevention of abuse. On August 23 & 27, 2012 the District Director of Clinical Ops conducted additional in-service training with Administrator, Director Nursing Service, Case Manager, MDS Coordinator, Housekeeping/Laundry Supervisor, Activity Director, Social Worker and Asst Director Nursing Service on "Conducting an Investigation on an Allegation of Abuse" which included but was not limited to immediacy of investigation, notifications, interviewing alleged victim, alleged perpetrator if known, interviewing witnesses including staff, residents, family members, family members, etc which included the facility Director of Social Services. On August 27, 2012 the District Director of Clinical Ops provided the Director of Social Services with additional in-service education on documentation of interviews, follow-up assessments, and referrals to physician and/or psychological services if indicated. The Director of Social Services will be notified of any alleged reports of abuse by the Administrator, Director Nursing Service or Asst Director Nursing Service. The Director of Social Services will follow procedure for "Responding to and Investigating an Abuse Allegation" when notified of an alleged abuse. Those activities will include referral to appropriate psychological services, update care plan interventions based on the investigation, report changes to the resident plan of care and communicate to the rest of the IDT at the morning meeting (Mon-Fri), and documentation of the resident's psychosocial status and actions taken by the clinical personnel. The Administrator will monitor the Director of Social	
{F 490} SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	{F 490}		

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			<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Service's performance to validate that medically related social services are provided to the facility residents beginning 8/30/12 weekly X 4 weeks and then monthly X one quarter and then quarterly. When there is an allegation of abuse, the DNS or ADNS will review the documentation of the services provided by Director of Social Services during daily clinical rounds to validate that the psychosocial well being of the resident is being assessed, care planned and with interventions appropriately implemented. The administrator will perform sample reviews of the Director of Social Services documentation monthly beginning 8/30/2012. The results of these audits will be reviewed at the facility monthly Performance Improvement meeting. Concerns or recommendations on the Director of Social Services documentation will be obtained and communicated by the administrator.</p>		

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{F 490}	<p>Continued From page 15</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, and observation of the physical plant, the facility failed to administered in a manner to protect one Resident (#1) with Alzheimer's Disease (a common type of Dementia, in which a loss of mental ability is severe enough to interfere with normal activities of daily living) from sexual abuse; failed to ensure policies and procedures were followed for investigating and implementing corrective interventions to ensure Residents were protected from further abuse of twelve Residents reviewed. The facility's failure has caused sexual abuse of one Resident (#1) and has placed other Residents at risk for abuse. The facility's failure placed all Residents with Dementia in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Resident).</p> <p>The facility provided a Credible Allegation of Compliance on August 30, 2012. A revisit conducted on September 6, 2012, revealed the corrective actions implemented on August 30, 2012, removed the Immediate Jeopardy.</p> <p>Non-compliance for F-490 continues at an "E" level citation (potential for more than minimal</p>	{F 490}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F490 - The facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. On August 23, 2012 the Corporate District Director of Clinical Operations and the Corporate State Director of Risk Management conducted training with the Administrator, Director of Nursing Service, MDS Coordinator, Director of Social Services, Business Office Manager, Activity Director, RN Case Manager, Staff Development Coordinator, Admissions Coordinator and the contract Housekeeping Services Supervisor on the corporate/facility procedures for investigating allegations of abuse. The corporate procedures addressed were Responding to and Investigating an Abuse Allegation, Conducting an Investigation, and Protection of Resident During An Investigation. On August 27, 2012 the District Director of Clinical Operations conducted the same training with the Assistant Director of Nursing.</p> <p>Areas addressed included, providing immediate protection to any resident involved in an alleged abuse, immediate notification of the Administrator and Director of Nursing Services, (or designated alternate manager i.e. Assistant Director of Nursing, MDS Coordinator, RN Case Manager, Director of Social Service,) and notification of the physician and family. The Administrator and Director of Nurses (or designated alternate) will report promptly to the facility to initiate the investigation using the "Alleged Abuse Investigation Worksheet". The Administrator will notify the VP of Operations and The Director of Nursing will notify the District Director of Clinical Operations of the abuse allegation.</p> <p>The Administrator will call and update the VP of Operations on allegation of abuse investigations status at least every other day until investigation complete and then report their findings and conclusions. The Director of Nursing will call and update the District Director of</p>		9/13/12

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NAME OF PROVIDER OR SUPPLIER

FAIRPARK HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

307 N FIFTH ST BOX 5477

MARYVILLE, TN 37801

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{F 490}	<p>Continued From page 16 harm).</p> <p>The findings included:</p> <p>Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, in-service reviews, and interviews with Residents, facility staff, including administrative and security guard staff.</p> <p>Resident #1 was discharged to another facility on August 16, 2012.</p> <p>The facility provided evidence Residents and families of non-interviewable Residents were interviewed for allegations of abuse; no abuse was alleged.</p> <p>The facility provided evidence the Interdisciplinary Team assessed, identified, and updated care plans of Residents who may be at a higher risk for abuse.</p> <p>The facility provided evidence of updated background checks on all male staff except two, with no negative findings. The delay in the two background checks is due to previous out-of-state residences, and the Administrator confirmed the results are expected at any time.</p> <p>The facility provided evidence of a security assessment completed on August 30, 2012, by a police officer with recommendations to hire a security guard, to provide additional security.</p> <p>The facility provided evidence of around-the-clock interim security personnel effective August 30,</p>	{F 490}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Clinical Operations of the abuse allegation investigation at least every other day until investigation completed and then will call and report their findings and conclusions. The District Director of Clinical Operations or VP of Operations will follow-up with a facility visit within one week of reported completion to review the written investigation.</p> <p>On August 3, 2012 the facility was informed that the allegation of rape made in June by Resident #1 was now being considered as having possibly occurred due to the results of the forensic testing. Resident #1 was discharged from facility on August 16, 2012. An audit was conducted by VP of Clinical Ops on August 30, 2012 of all events occurring from January 1 2012 to August 30 2012. no other events of alleged sexual abuse had occurred. An additional audit was conducted by the Staff Development Coordinator on 8/22/2012 to ensure that families and physicians had been notified of all events occurring from 6/15/2012 to 8/22/12 and no issues noted.</p> <p>Interviewable residents and families of non interviewable residents were questioned by the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Business Office Manager, Activity Director, Director of Social Services, Admissions Coordinator, Director of Medical Records, Infection Preventionist, Certified Dietary Manager, Case Manager, MDS Coordinator, and Rehab Tech (C.N.A.) between August 23 and August 28, to determine if there were any further allegations related to staff treatment, did residents feel they were treated with respect, had residents witnessed any unusual visitors, strangers or had concerns about any staff members. The interviews did not produce any other allegations of sexual abuse nor give potential leads for suspects. It was the understanding of the Executive Director that the facility not re-interview staff members in August at the request of the local police department. The police advised the facility that in doing so it may</p>	

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{F 490}	<p>Continued From page 17</p> <p>2012, through September 4, 2012. A contract for around-the-clock security personnel was obtained effective September 5, 2012; and the contract does not identify a termination date.</p> <p>The facility provided evidence of a revised policy, Abuse Prohibition.</p> <p>The facility provided evidence a Security Workgroup had been developed to ensure enhanced security measures were identified and implemented.</p> <p>Observation of the 100 hall Medication Administration Record confirmed a copy of Residents' care plans who are at high risk for potential abuse.</p> <p>Observation of the Certified Nursing Assistant Flowsheet book confirmed a copy of Residents' care plans who are at high risk for potential abuse.</p> <p>Observation of the front lobby confirmed a security guard was constantly present except for breaks, which are covered by facility staff. Visitors were observed to sign-in on the visitor's log upon entering the facility; and sign-out upon exit. When the front door is locked down, beginning at 6:00 p.m., the security guard makes random, periodic rounds inside from the front lobby to the courtyard door, outside rounds are made around the building, to include the inside and outside of the courtyard. The security guard confirmed routine, timed, rounds are avoided, to ensure a pattern is not established and discovered by a potential perpetrator.</p>	{F 490}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>impede or interfere with correctly conducting the criminal investigation in order to determine and prosecute the perpetrator. The police officer indicated that this was now his investigation and he wanted to be the person to question male staff employees and procure DNA samples. The facility agreed to fully comply with the request of the local police and did so based on policy and procedure of the facility "Responding to and Investigating an Abuse Allegation.</p> <p>The interdisciplinary team consisting of MDS coordinator, RN Case manager, Director of Social Services, Activity Director, Registered Dietician and Certified Dietary Manager identified the residents on 8/29/2012 that may be at higher risk for abuse due to dementia diagnosis, infrequent or no visitors, behavioral issues, or those who are bedfast and dependent on care. The interdisciplinary team met on 8/29 and 8/30/2012 to identify care plan goals and interventions to assist in the prevention of abuse. This increased focus on residents who may be at higher risk for abuse has been communicated to the Certified Nursing Assistant staff via their assignment sheet and by placing a copy of the resident care plan for higher risk of potential abuse "Social Isolation" in the C.N.A flow sheet book. Licensed nurses have a copy of the resident care plan for higher risk of potential abuse, "Social Isolation, with the resident's Medication Administration Record.</p> <p>The Activity Director and Director of Social Service conducted a Resident Council meeting on 8/29/2012 to discuss any security concerns of the residents. During this meeting the residents indicated to the Administrator that they felt safe here.</p> <p>The corporate Human Resource department is obtaining updated background checks on all male employees on 8/30/2012 to identify any current issues. Updated background checks on all male employees hired before 6/15/2012 has been completed and all are negative.</p> <p>A security assessment was completed on 8/30/2012 by a</p>		

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(F 490)	<p>Continued From page 18</p> <p>Observation of the service hall entrance confirmed the doors were locked and required staff to open the doors from the inside. Review of the vendor sign-in sheets revealed the sheets were being completed according to policy.</p> <p>Observation of the courtyard door confirmed codes are required to enter and exit. Continued observation confirmed staff covered the code pad to prevent unauthorized individuals from obtaining the code.</p> <p>Observation of the camera monitor confirmed three cameras were in operation and recording activity from the (1) front entrance, (2) service hall entrance, and the (3) employee locker room. The recording device and monitor is positioned in the front business office. The facility provided evidence recordings are reviewed daily, to ensure compliance with the visitor and vendor sign-in/out requirements (at the front and service hall doors).</p> <p>Observation of random Residents' rooms confirmed wooden dowels were present in the window thresholds to deter outside entry.</p> <p>The facility provided evidence the Administrator was in-serviced related to policies and procedures for updated security measures; Abuse; Responding to and Investigating an Abuse Allegation; the Elder Abuse Act; Conducting an Investigation; and Protection of a Resident During an Investigation.</p> <p>Interview with the Administrator confirmed the Administrator received in-services related to policies and procedures for updated security measures; Abuse; Responding to and</p>	(F 490)	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>police officer of the City of Maryville. The officer conducted a tour of the facility as well as the grounds of the facility. A verbal recommendation from the officer was for the facility to hire a security guard around the clock to better ensure that visitors were signing in appropriately and provide additional security. The center has obtained security personnel through the Blount County Sheriff Department starting 8/30/12 until a replacement security contract is obtained. The facility will re convene the Performance Improvement security workgroup at that time to evaluate the recommendations and present them to the Performance Improvement Committee for review and action. The members of the Security Workgroup are: Maintenance Director, Administrator, Director of Nursing, Activity Director, Staff Development Coordinator, Housekeeping Supervisor and Patient Relations Coordinator. Facility policies and procedures were reviewed by the Administrator, Director of Nursing and District Director Clinical Operations on 8/30/12. Two minor changes were made to the written policy and procedures. On 8/21/12 an Addendum to Facility's Abuse Prohibition Policy and Procedures was made to clarify the term visitors to include both family/friends as well as other professional consultants or visitors such as but not limited to: Paramedics, EMT's, Radiological Techs, laboratory techs, Physicians, Nurse Practitioners, clergy, attorneys, and legal representatives. On 8/30/2012 the policy on "Notification", was amended to add that physicians will be notified for lab test results or other test results returned from another laboratory or healthcare site that the resident was seen. The Administrator conducted in-services for facility staff on definitions of abuse, recognizing signs of possible abuse, protection of resident, Elder Abuse Act. These in-services were conducted beginning on 7/30/12, 7/31/12, 8/9/12, 8/22/12 and 8/24/12 for facility employees. Staff who are on leave, vacation, PRN, etc will not be allowed to return to work until receiving the</p>		

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		F490	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>unlock/lock and monitor gate during this type of activity. The key is secured in the maintenance office. Only Maintenance and Administrator have access to the key. The service door, which is for staff and vendor access only, is locked 24 hours a day/7 days a week. Staff may use access code to exit and enter. Vendor/delivery personnel must ring bell and have staff open the door, the staff that opens the door is responsible to have vendor sign-in and sign out upon completion. The vendor sign in sheet is located at the delivery entrance. The Administrator, Maintenance Director, (Plant Ops Manager), Director of Nursing, Business Office Manager, Asst. Director of Nursing or assigned week-end duty manager will monitor the vendor logs daily to ensure that vendors are signing in and out. Windows and screens were checked from the exterior on Aug 16, 2012 and found to be secure by the maintenance director. To make resident room windows so that they cannot be opened from the outside by an "intruder, wood dowels were placed in the inside slides track to prevent the windows opening greater than 6 inches on August 14, 2012. The facility has purchased windows locks for the resident room windows and after approval from the State of Tennessee, Dept. of Health, Health Care Facilities Engineering were installed on 9/13/2012. All non- resident room windows are currently secured by an inside lock. The maintenance director, maintenance assistant, assigned week-end duty manager are checking the resident room windows daily to validate the current safety device is in place. Currently there are 3 camera's attached to a motion detector that records when there is movement detected. The cameras visualize the front entrance (installation 8/10/12), the vendor entrance (installation began on 8/30 and completed on 8/31/2012, and the employee locker room (installed in 2010). This recording will provide the facility with evidence to review if there are any events such as employee theft, or other events that occurred, its intent is not to use as real time monitoring</p>		

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NAME OF PROVIDER OR SUPPLIER

FAIRPARK HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

307 N FIFTH ST BOX 5477

MARYVILLE, TN 37801

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		F490	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>but provide a retrospective review. This is another mechanism for monitoring the compliance of the visitor and vendor sign in procedure. Results of daily review of the recordings will be reported in the weekday morning meeting. At the present time it is reviewed daily by the maintenance director (Plant Ops Manager) or the Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, 3 Business Office Assistants, Activity Director, Activity Assistant, Director of Social Services, Director of Admissions, Director of Medical Records and Data Entry Clerk. It is possible to watch the camera real time if circumstances warrant. The front entrance is locked down beginning at 6 pm. Visitors must ring the bell and security personnel or staff respond to allow visitors to enter and exit the facility. A "visitor's log" placed at the receptionist area is monitored by the security guard to ensure that visitors sign in and out.</p> <p>The Administrator conducted in-services for staff on the facility's updated security measures on August 18, 19, 21, 23, 24, and 28, 2012. Employees on leave of absence, vacation, etc. upon return will receive the same in-service on prevention measures by their department head or designee, prior to reporting to their job area. On August 23, 2012 the District Director of Clinical Operations conducted additional in-service training with Administrator, Director of Nursing, Case Manager, MDS Coordinator, Housekeeping/Laundry Supervisor, Activity Director, Social Worker and Asst. Director of Nursing on "Conducting an Investigation on an Allegation of Abuse" which included, but was not limited to, immediacy of investigation, notifications, interviewing alleged victim, alleged perpetrator, interviewing witnesses including staff, residents, family members, etc.</p> <p>The maintenance director, Administrator, Business Office Manager or assigned weekend duty managers will be responsible to view the video taping of the front lobby, the employee locker room and the vendor</p>	

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		F490	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>entrance and report any concerns to the facility administrator daily. Any staff member not in compliance with enhanced security measures will be disciplined as appropriate. New hires will receive facility orientation to the centers enhanced security measures.</p> <p>The Facility's Performance Improvement Committee (Administrator, Director of Nursing, Medical Director, Asst. Director of Nursing, Staff Development Coordinator, Business Office Manager, RN Case Manager, MDS Coordinator, Activity Director, Director of Social Services, Certified Dietary Manager, Plant Ops Manager, Admissions Coordinator) met on August 21, 2012 to address issues of security. Updates to the security measures will be provided, effectiveness of measures will be reviewed and further recommendations made as needed. The Administrator/Director of Nursing/Staff Development Coordinator will track and trend events such as injury of unknown origin, information from resident/family interviews and allegation of abuse investigations, if any, to monitor and evaluate facility's abuse prevention program. The Director of Nursing will continue to present to the Facility Performance Improvement Committee (Administrator, Director of Nursing, Medical Director, Asst. Director of Nursing, Staff Development Coordinator, Business Office Manager, RN Case Manager, MDS Coordinator, Activity Director, Director of Social Services, Certified Dietary Manager, Plant Ops Manager, Admissions Coordinator) at its monthly meeting any/all investigations of allegations of abuse that includes a review of compliance with the facility's P&P on Abuse Prevention & Investigation for review, discussion and recommendations, if indicated.</p>		

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{F 490}	Continued From page 19 Investigating an Abuse Allegation; the Elder Abuse Act; Conducting an Investigation; and Protection of a Resident During an Investigation; and related notifications and documentation. Interviews with random facility licensed and certified nursing staff, dietary and housekeeping staff, the Director of Nursing, and the Administrator, during the revisit, confirmed they had received in-services related to policies and procedures for updated security measures; Abuse; Responding to and Investigating an Abuse Allegation; the Elder Abuse Act; Conducting an Investigation; and Protection of a Resident During an Investigation; and related notifications and documentation. The facility remains out of compliance at an "E" level until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.	{F 490}	This Plan of Correction is the center's credible allegation of compliance. <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
{F 520} SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	{F 520}	FS20 The Administrator, the Director of Nursing, and a nurse consultant met on 8/21/2012 to review several of the Facility policies and procedures that were the subject of the deficiencies cited during the August 20, 2012 survey. Those policies included the policy governing physician notification, the policy governing use of the 24-Hour Report, the Procedure for test results, and the abuse policy, abuse prevention, conducting an investigation protection of a resident during an investigation responding and investigating an abuse allegation, reporting reasonable suspicion of a crime. Two minor changes were made to the written policy and procedures. On 8/21/12 an Addendum to		9/13/12

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(F 520)	<p>Continued From page 20</p> <p>develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, review of the facility investigation, review of facility training program, review of facility policy, review of payroll hours, review of an interview schedule, review of a sexual assault forensic report, observation, interview, and review of video surveillance, the facility's Quality Assurance (QA) Committee failed to maintain an effective QA program to protect one Resident (#1) with Alzheimer's Disease (a common type of Dementia, in which a loss of mental ability is severe enough to interfere with normal activities of daily living) from sexual abuse; failed to ensure policies and procedures were followed for investigating and implementing corrective interventions to ensure Residents were protected from further abuse of twelve Residents reviewed. The facility's failure has caused sexual abuse of one Resident (#1) and has placed other Residents at risk for abuse. The facility's failure placed all Residents with Dementia in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of</p>	(F 520)	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Facility's Abuse Prohibition Policy and Procedures was made to clarify the term visitors to include both family/friends as well as other professional consultants or visitors such as but not limited to: Paramedics, E.M.T.'s, Radiological Techs, laboratory techs, Physicians, Nurse Practitioners, clergy, attorneys, and legal representatives. On 8/30/2012 policy on "Notification" was amended to add that physicians will be notified for lab test results or other test results returned from another laboratory or healthcare site that the resident was seen. The Administrator conducted in-services for facility staff on definitions of abuse, recognizing signs of possible abuse, protection of resident, Elder Abuse Act. These in-services were conducted beginning on 7/30/12, 7/31/12, 8/9/12, 8/22/12 and 8/24/12 for facility employees. Staff who are on leave, vacation, PRN will not be allowed to return to work until receiving the same in service. On August 6 the facility convened a Performance Improvement Security Workgroup meeting. The members of the Security Workgroup are: Maintenance Director (Plant Ops Manager), Administrator, Director of Nursing, Activity Director, Staff Development Coordinator, Housekeeping Supervisor and Customer Service (Patient Relations) Coordinator. At this meeting a discussion of enhanced security measures that should be put in place were identified. New hires will receive facility orientation to the centers enhanced security measures.</p> <p>On 8/21/2012 the Performance Improvement Committee (Administrator, Director of Nursing, Medical Director, Asst. Director of Nursing, Staff Development Coordinator, Business Office Manager, RN Case Manager, MDS Coordinator, Activity Director, Director of Social Services, CDM, Plant Ops Manager, Admissions Coordinator) again convened to delegate responsibility for development of corrective action to appropriate members of the Facility's management staff. During this meeting the Committee</p>	

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{F 520}	<p>Continued From page 21</p> <p>participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Resident).</p> <p>The facility provided a Credible Allegation of Compliance on August 30, 2012. A revisit conducted on September 6, 2012, revealed the corrective actions implemented on August 30, 2012, removed the Immediate Jeopardy.</p> <p>Non-compliance for F-520 continues at an "E" level citation (potential for more than minimal harm).</p> <p>The findings included:</p> <p>Validation of the Credible Allegation of Compliance was accomplished through medical record review, facility policy review, in-service reviews, and interviews with facility staff, including administrative staff.</p> <p>Resident #1 was discharged to another facility on August 16, 2012.</p> <p>The facility provided evidence the Performance Improvement Committee reviewed the Abuse and Abuse-related policies. Policies reviewed included Physician Notification; Use of the 24-Hour Report; Abuse; Abuse Prevention; Conducting an Investigation; Protection of a Resident during an Investigation; Responding and Investigating an Abuse Allegation; and Reporting Reasonable Suspicion of a Crime. The review produced revisions to two policies, (1) Abuse Prohibition Policy, and (2) Notification, related to diagnostic testing.</p>	{F 520}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>discussed and reviewed several of the policies and procedures, including physician notification, use of the 24-Hour Report, and the procedures for test results. The Medical Director provided clinical input regarding these policies at that time. The Committee also discussed the status of the action plans for each deficiency.</p> <p>The Performance Improvement Committee (Administrator, Director of Nursing, Medical Director, Asst. Director of Nursing, Staff Development Coordinator, Business Office Manager, RN Case Manager, MDS Coordinator, Activity Director, Director of Social Services, Certified Dietary Manager, Plant Ops Manager, Admissions Coordinator) agreed, in the interim, to meet weekly to monitor progress with the corrective action plan. These weekly meetings will continue until the survey team has determined that facility is in substantial compliance.</p> <p>The Performance Improvement Committee (Administrator, Director of Nursing, Medical Director, Asst. Director of Nursing, Staff Development Coordinator, Business Office Manager, RN Case Manager, MDS Coordinator, Activity Director, Director of Social Services, Certified Dietary Manager, Plant Ops Manager, Admissions Coordinator,) agreed to meet on a monthly basis thereafter to discuss the Facility's progress and to assure that the Facility remains in substantial compliance with all of the Requirements of Participation. The Committee has agreed that those individuals who are responsible for overseeing the corrective action implemented in response to the August 20, 2012 Statement of Deficiencies will present summaries of their monitoring efforts during each meeting until the facility has achieved substantial compliance. A member of the Performance Improvement Committee will be responsible to take minutes of each meeting and distribute the minutes to all members prior to the next monthly meeting.</p> <p>The Committee has agreed periodically to review in-</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/06/2012
NAME OF PROVIDER OR SUPPLIER FAIRPARK HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 307 N FIFTH ST BOX 5477 MARYVILLE, TN 37801		
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{F 520}	<p>Continued From page 22</p> <p>The facility provided evidence the Performance Improvement Committee met on weekly basis to review the corrective action progress.</p> <p>The facility provided evidence a Performance Improvement Security Workgroup had been developed to ensure enhanced security measures were identified and implemented.</p> <p>Interview with the Administrator confirmed upon removal of the Immediate Jeopardy, the Performance Improvement Committee will continue to meet monthly, or more frequently, as needed.</p> <p>The facility remains out of compliance at an "E" level until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.</p>	{F 520}	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>service training agendas and orientation training packages to assure that the material provided is consistent with current regulatory requirements and with the Facility's current policies and procedures. The Committee has agreed to evaluate its effectiveness every six months.</p>		